LEILIE JAVAN, MD, FACS
A Medical Corporation
425 Haaland Drive, Suite 203, Thousand Oaks, CA 91361
(805) 381-9800 – phone (805) 496-8480 – fax

HIPAA AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize Leilie Javan M.D. and staff as designated by her to release the following information:

_____General information about my care _____ Laboratory/Pathology results

_____Surgery Status _____Instructions for care

_____Medication Instructions _____Appointment Information

to the following individuals:

_____husband _____wife

_____daughter _____son

_____mother _____father

_____other (indicate relationship) _____

This communication may take place:

In person _____ By phone/voicemail _____ In writing _____

This authorization shall remain in effect until _____
OR
Until I rescind it in writing_____

Patient's Name

Patient/Guardian Signature _____Date_____

Guardian's
Name_____Relationship_____